



# Home Health Care Questionnaire

Supplemental to  
Fully Completed ACORD 130 Workers' Compensation Application

<b>Applicant Name:</b>	<b>Effective Date:</b> _____
<b>Website:</b>	<b>FEIN:</b> _____

<b>Description of Operations – include % of personal care and skilled care services provide</b>

<b>Operations</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Employee health care plans provided
	How many independent contractors / 1099 employees used?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you verify workers comp coverage for independent contractors?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you lease out employees or provide temp staffing to outside clients?
_____ %	If yes, what is the % of payroll leased or temp staffing to others?

<b>Client Profile</b>	
_____ % Non-Ambulatory	_____ % Physically Disabled
_____ % Alzheimer/ Dementia	_____ % Developmentally Disabled
_____ % Hospice Patients	_____ % Elderly

<b>Hiring Practices</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Written application & personal interview
<input type="checkbox"/> Yes <input type="checkbox"/> No	Written job description provided to applicant
<input type="checkbox"/> Yes <input type="checkbox"/> No	Criminal background check / reference check / work history validated
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pre-hire drug testing
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pre-hire physical fitness test
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are certifications/ licenses verified?

<b>Employee Training</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	New employee orientation training
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient/client handling & transfer training
<input type="checkbox"/> Yes <input type="checkbox"/> No	Combative patient/client training
<input type="checkbox"/> Yes <input type="checkbox"/> No	Slip, trip & fall avoidance training
<input type="checkbox"/> Yes <input type="checkbox"/> No	Regular formal safety training and/or meetings

Safety Practices & Programs				
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Formal written safety/Injury & Illness Prevention program
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	MVR's checked annually
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Non-slip footwear required
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Formal accident/injury investigation and claims reporting process
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Safety incentive program
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Clients' premises pre-inspected for safety hazards
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Screen workers regularly for signs and symptoms of COVID
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Ensure all workers have proper personal protective equipment (PPE)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Instruct sick workers to stay at home
Describe any other safety practices or programs you have:				

Claims Management				
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Formal Return to Work or Modified Duty Program
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Light duty job descriptions established
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Designated person to manage workers' compensation claims
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Relationship established with a preferred medical provider
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Safety incentive plan for employees and supervisors
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Post-accident drug testing program for all workplace injuries